Interviewing Methods

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Depressive Disorders

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This chapter will focus on new developments in the use of standardized interview methods for the diagnosis of affective and other mental disorders in patient, community, and cross-cultural samples. Discussion will be limited to instruments used to derive diagnoses; instruments that quantify severity or measure symptom change, such as the Hamilton Depression Rating Scale (Hamilton, 1960), are not included.

BACKGROUND AND HISTORY

Over the past three decades, increasing emphasis has been placed on the explication and refinement of diagnostic nosology and on the development of standardized interviewing techniques for deriving differential diagnoses. Although the classification and description of affective disorders is still a controversial and continually evolving process, three diagnostic systems have dominated the clinical and research fields: the Feighner criteria (Feighner et al., 1972), the Research Diagnostic Criteria (Spitzer, Endicott, & Robins, 1978), and the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders,* DSM-III(1980) and DSM-III-R(1987).

Prior to the 1950s, the primary sources of information about mental disorders were textbook descriptions, reported case histories, and clinical presentations. The clinician's interview was the method by which this information was obtained. Early attempts to develop a classification system, nomenclature, and standard descriptions of mental disorders began in 1952 with the publication of the first *Diagnostic and Statistical Manual* (DSM-I) by the American Psychiatric Association. In the early 1970s, trends toward the specification and standardization of diagnostic categories culminated in the publication of the Feighner criteria. This publication, a milestone for the development of a reliable and valid nosology, described diagnostic criteria for 14 psychiatric disorders. These included a distinction between primary affective disorders (depression and

mania) and secondary affective disorders (depression or mania in the presence of another preexisting nonaffective disorder or a life-threatening physical illness). Although these criteria, derived from clinical and research experience, were not considered definitive for any category, they offered a method of uniformly communicating and describing patients' conditions.

In addition, Feighner et al. (1972) described five phases for demonstrating diagnostic validity in psychiatric disorders:

1. Clinical description—the phenomenological description of the condition.

2. Laboratory studies—the discovery or development of physiological, chemical, and anatomical findings that are consistently and reliably found in the presence of the specific disorder.

3. Delimitation from other disorders—the description of exclusion criteria for overlapping conditions so that the disorder defined describes the most homogenous group.

4. Follow-up studies—used to describe the outcome of the original clinical condition. It is postulated that in the absence of knowledge about the etiology of a condition, marked differences in outcome would suggest that the original cases did not comprise a homogenous group or were inaccurately diagnosed. Diagnostic heterogeneity, or change in the condition, has been regarded as a threat to the validity of the original diagnosis.

5. Family studies—based on the observation that many disorders run in families. The assumption that a high prevalence of illness in family members increases the likelihood of a valid diagnosis is made independently of the etiology (genetic versus environmental) of the condition.

Although these advances in the development of criteria for diagnostic categories moved the field closer to uniform sets of diagnostic criteria, standardized uniform procedures for collecting requisite information were absent.

Concerns with both the validity of psychiatric disorders and the reliability of diagnosis motivated the development of structured diagnostic interviews to be used with explicit criteria or classification schemes. It has long been recognized that diagnostic disagreement results from a lack of reliability or from inconsistencies occurring in the clinical interview. There are two fundamental sources of these disagreements: *information variance* and *criterion variance.* Information variance (Spitzer, Endicott, & Robins, 1975) refers to the different resources the clinician may use to gather information about a patient's condition. For example, one clinician may always interview family members as a source of data about a diagnosis, and another clinician may routinely question the patient about symptoms and difficulty in functioning, but neither of these clinicians may routinely use both sources. The end result is diagnostic disagreement between these two clinicians.

Criterion variance refers to the rules of inclusion or exclusion used by the clinician to establish a diagnosis. For example, in DSM-III the diagnosis of Panic Disorder is excluded if Agoraphobia is diagnosed, whereas in DSM-III-R Panic Disorder may be diagnosed as coexisting with Agoraphobia. Other sources of variability that contribute to error in the clinical interview originate in the patient's presentation (subject variance) and in changes in the disorder over time (occasion variance). Another source of unreliability, observation variance, refers to the clinician's differential focus on aspects of the patient's presentation. For example, one clinician may emphasize agitated behavior while another may emphasize suicidal ideation.

There are two methods for controlling these sources of variance. One is to reduce information variance with the use of structured clinical interviews. The other is to develop more uniform, standardized descriptions, names, and guidelines for diagnostic categories (Spitzer et al., 1975). These methods, in conjunction with instruction of clinicians in observational and interviewing techniques, will serve to greatly reduce variability in the clinical interview.

In the mid-1970s the National Institute of Mental Health (NIMH) Clinical Research Branch Collaborative Program on the Psychobiology of Depression sponsored the development of interview procedures and diagnostic criteria for the purpose of establishing reliable procedures for making diagnostic judgments. The commonly used structured diagnostic interview schedules and their

companion diagnostic criteria are described here in detail.

DIAGNOSTIC INTERVIEW SCHEDULES AND COMPANION DIAGNOSTIC CRITERIA

The Schedule for Affective Disorders and Schizophrenia (SADS)/The Research Diagnostic Criteria (RDC)

The Schedule for Affective Disorders and Schizophrenia (SADS; Endicott & Spitzer, 1978) and the Research Diagnostic Criteria (RDC; Spitzer et al., 1978) are products of the NIMH Clinical Research Branch Collaborative Program. The SADS is a standardized, semistructured interview designed to gather systematically the information needed to derive a differential diagnosis for the 25 diagnostic categories of the RDC. The SADS follows the rhythm of a clinical interview and uses a three-pronged format of questioning about mood, symptoms, and impairment. The sequence of questions provides information that includes or excludes other specific diagnoses. In addition, the SADS gathers descriptive information about the course of illness, the age of onset, the number and duration of episodes, and other associated features.

There are three versions of the SADS: (a) the Regular Version (SADS), (b) the Lifetime Version (SADS-L), and (c) the Change Version (SADS-C). The Regular Version is organized into two parts. Part I focuses on the phenomenology of the current condition and documents the features of the current condition for two fixed time periods, the week prior to the interview and the time when the condition was at its worst in the recent course of the illness. Part I permits the

quantification of current symptoms on a six-point severity scale for both time periods, a feature that makes the SADS an appropriate measure of change. Part I also permits for subtyping, which has facilitated the testing of hypotheses related to the course and onset of certain subtypes of affective disorders, such as endogenous depression. In contrast, Part II derives a lifetime description of the condition by focusing on both the description of past periods of illness and the current problem.

The SADS Regular Version is useful for interviewing inpatients or outpatients for both current episodes of illness and follow-up studies of treatment outcome.

The Lifetime Version of the SADS (SADS-L) is similar to Part II of the SADS Regular Version; however, the time period assessed by the SADS-L is only the past. This version of the SADS is useful for assessing inpiduals who have no current episode of illness and is appropriate for cases in which extensive information about the phenomenology of the disorders is not needed. SADS-L is useful for interviewing outpatients or for interviewing relatives of patients about themselves, and has been used with community populations to obtain information about the prevalence and incidence of these disorders.

The Change Version (SADS-C) contains the subset of items from Part I of the SADS which includes scales to measure the level of severity in the week prior to

the evaluation and is therefore an efficient way to quantify change in the current condition. The SADS-C assesses change in the presentation of symptoms for current conditions or episodes of depression, mania, anxiety, alcohol and drug abuse, psychosis, or schizophrenia. It is most useful for documenting change in the conditions of inpatients or outpatients.

Which Affective Disorders Are Diagnosed by the SADS Interview?

Manic Disorder, Hypomanic Disorder, Bipolar with Mania (Bipolar I), Bipolar with Hypomania (Bipolar II), Major Depressive Disorder, nine subtypes of Major Depressive Disorder (i.e., Primary, Secondary, Endogenous, Situational), Minor Depressive Disorder, Intermittent Depressive Disorder, Cyclothymic Personality Disorder, and Labile

Personality are all diagnosable. “Rule-outs” are included to differentiate Schizoaffective Depressed or Manic from these affective disorders.

Who Administers the SADS?

Inpiduals knowledgeable about psychopathology and experienced in interviewing clinical populations, such as psychiatrists, clinical psychologists, and psychiatric social workers, are most suited for administering the SADS because the SADS requires the interviewer to make judgments about the clinical concepts and symptoms. The SADS may be administered by research personnel or other

professionals working in the field who have had special training. Training of personnel in the administration of the SADS is facilitated by the use of videotaped SADS interviews, role playing, and direct interview with patients (Gibbon, McDonald-Scott, & Endicott, 1981). The authors of the SADS have developed an interviewer manual which includes guidelines for conducting the interview as well as definitions of terms.

How Much Time Is Required to Administer the SADS?

An experienced interviewer requires about 1 *xfi* to 2 hours to administer a SADS interview. This time will vary with the version of the SADS used, the details of the history, and the mental condition of the interviewee.

Reliability

Psychometric information about the SADS Regular Version was obtained from four treatment facilities participating in the NIMH-sponsored Pilot Study of the Psychobiology of Depressive Disorders (Endicott & Spitzer, 1978). Joint interview and test-retest methods of testing reliability were used with 150 inpatients admitted with a diagnosis of Mania or Major Depression. Joint interview intraclass coefficients ranged from .82 to .99. Test-retest reliabilities for 60 inpatients retested over a time period of 48 hours to one week ranged from .49 to .93 (intraclass r). The SADS items were highly internally consistent, as demonstrated by Cronbach alphas of .97 for Mania and .83 to .88 for Major

Depression. The exceptions were for items assessing Formal Thought Disorder (Cronbach alpha = .47) and Anxiety (Cronbach alpha = .58).

Validity

Concurrent validity for SADS items was tested with scales measuring both patients' and relatives' reports of the patient's condition. The Katz Adjustment Scale for the subject (KAS-S) and for the relatives (KAS-R) and the Symptom Checklist 90 (SCL-90) were used. The correlations ranges (r) of the SADS depression-related items were: with the KAS-R, r = .42 to .58; with the SCL-90, r = .47 to .68; and with the KAS-S, r = .37 to .46 (Endicott & Spitzer, 1978). Overall, there is some evidence for SADS concurrent validity for patient self-reported depression items. The SADS has been shown to be useful for discriminating between groups and for testing hypotheses about the classification and subtyping of affective disorders (Cornell, Milden, & Shimp, 1985; DeJonghe, Ameling, & Assies, 1988; Endicott & Spitzer, 1979). The SADS interview and RDC diagnostic manual appear to derive relatively stable lifetime diagnoses. Diagnostic agreement after a follow-up interval of 1 ½ to 2 years was Kappa = .83 for Mania and Kappa = .76 for Major Depression (Spitzer et al., 1978).

Scoring

Precoded score sheets for the various SADS interviews and RDC have been developed. The advantage of the SADS scoring in comparison to other instruments

is that the SADS interviews may be scored by the interviewer using the RDC manual. Computerized scoring algorithms have also been developed by researchers to score the SADS using RDC criteria. Good agreement has been reported between computer-generated diagnoses and interviewer-generated diagnoses. However, the major constraint for computer-generated diagnoses is the limitations of the diagnostic system (Spitzer, Endicott, Cohen, & Fleiss, 1974).

Availability

The SADS interviews and RDC manuals are available from the Research Assessment and Training Unit, 722 West 168 Street, Room 341, New York, NY 10032. In addition, the Research Assessment and Training unit offers material for instruction in the use of the SADS and RDC. The SADS has been translated into some foreign languages. Versions are available in Spanish, French, and Japanese, among others (Miriam Gibbon, personal communication, May, 1989).

Diagnostic Interview Schedule (DIS)/Feighner Criteria; Research Diagnostic Criteria; DSM-III (1980) and DSM-III-R (1987)

The National Institute of Mental Health (NIMH) Diagnostic Interview Schedule (DIS) was developed by Robins and her colleagues (Robins, Helzer, Croughan, & Ratcliff, 1981) at the specific request of the pision of Biometry and Epidemiology of NIMH for use in large-scale epidemiological studies. The immediate application of the DIS was for the Epidemiological Catchment Area

(ECA) projects for gathering data on the prevalence of psychopathology and psychiatric disorders in the community at large (see Regier et al., 1984, for details). There was need for an instrument that could be administered by a nonclinician interviewer but would be capable of deriving differential diagnoses. The Renard Diagnostic Interview (RDI) (Helzer, Robins, Croughan, & Weiner, 1981), the predecessor of the DIS, had been developed and was fully specified in terms of initial questions and subroutines for probing. The RDI contained a symptom scoring system which permitted the scoring of presence or absence of a symptom with severity ratings as well as scoring for the presence of a symptom in the context of other conditions, such as drugs or medical illness. The RDI, therefore, was chosen to be the model on which the DIS was based. In addition, the DIS was specifically designed to meet the need for an instrument which could provide diagnostic information for three diagnostic systems: the Feighner criteria (Feighner et al., 1972), the RDC (Spitzer et al., 1978), and the DSM-III (American Psychiatric Association, 1980, 1987).

The DIS interview assesses information for 32 DSM-III diagnostic categories, nine of the 25 RDC diagnoses, and 14 of the Feighner criteria disorders (see Robins et al., 1981, for a detailed description). There have been three revisions of the DIS since its development and a new version that derives DSM-III-R diagnoses is near completion (Philip Leaf, personal communication, May, 1989).

The DIS is a structured interview designed to make complex diagnostic

decisions. A probe flow-chart method is utilized to carry the interviewer through the decision tree of positive or negative responses. The DIS Version Three contains approximately 263 items which inquire about respondents' symptoms or problems experienced currently or over a lifetime. Current symptoms are assessed for four time periods: the past two weeks, the past month, the past six months, and the past year. Other descriptive information, such as age at the last symptom, age at onset of the first symptom, or age at seeking medical help for the symptom, is also gathered. One of the features of the DIS is the differentiation of the diagnostic significance of symptoms, that is, the severity of the symptom and whether the symptom is attributable to physical illness. The DIS has been shown to be useful for identifying patients who are medically ill and who also have treatable psychiatric problems (Lustman, Harper, Griffith, & Clouse, 1986). The overlap between physical and psychiatric symptoms and the proper assignment of cause are difficult determinations in the process of differential diagnosis. The DIS, therefore, may be helpful in systematically studying the overlap between physical and emotional problems.

Which Affective Disorders Are Diagnosed by the DIS?

The DSM-III diagnoses are Major Depression, Dysthymic Disorder, Bipolar Disorder, and Manic Disorder; the Feighner criteria diagnoses are Depression and Mania; and the RDC criteria diagnoses are Major Depressive Disorder and Manic Disorder.

Who Administers the DIS?

The DIS was designed for administration by a nonclinician interviewer who is well trained in interview methods. Interviewers can be trained to administer the DIS in about two weeks. Clinically trained professionals may also use this instrument.

How Much Time Is Required to Administer the DIS?

An experienced interviewer can administer the DIS in 45 to 90 minutes.

Reliability

The initial psychometric properties of the DIS were tested on 216 inpatients, outpatients, and nonpatients. Reliability studies were conducted so that all subjects were interviewed twice, once by a nonclinician and once by a psychiatrist. Kappa coefficients of agreement fell around .60 for most disorders, with perfect agreement (1.00) for Anorexia Nervosa and Pathological Gambling but lower agreement (Kappa = .30) for Panic Disorder and Somatization Disorder. Recently, the DIS was administered to 220 psychiatric inpatients and compared to chart diagnoses. Agreement between DIS and chart diagnoses ranged from Kappa .39 to -.03 and was adequate for Affective Disorders but poorest for Phobias (Erdman et al., 1987).

Validity

Because the standard for validity for the DIS has been the psychiatrist's examination and diagnosis, the method for demonstrating validity has been to compare the lay interviewers' DIS to the psychiatrist's interview, conducted with or without the use of the DIS (Anthony et al., 1985; Helzer et al., 1985; Helzer, Spitznagel, & McEvoy, 1987). Helzer et al. (1985) reported that the agreement between lay interviewer and psychiatrist ranges from 79 to 96 percent for most diagnostic categories. Clinicians' diagnoses, upon reinterview, confirmed the diagnoses assigned by lay interviewers the majority of the time; for example, the lay interviewer DIS diagnosis of Major Depression was confirmed by the clinician 82 percent of the time. In contrast, Panic Disorder, Simple Phobia, and Obsessive-Compulsive Disorders showed confirmation rates at around 50 percent (Robins, Helzer, Ratcliff, & Seyfried, 1982). Lay interviewers have been reported to underdiagnose Major Depression (Anthony et al., 1985), Alcohol Dependence, Somatization Disorder, and Panic Disorder (Robins et al., 1982) and to overdiagnose Obsessive-Compulsive Disorder (Anthony et al., 1985). Diagnoses most accurately assigned by lay interviewers were for those cases with current and severe disorders. While there is some concern about the inconsistencies in lay versus clinician diagnoses, investigators have attributed the diagnostic variability to problems with the standard (the use of the psychiatrist's diagnosis as the validity criterion), the reinterview method, and the limitations of the Kappa statistic (Robins, 1985).

An alternative method of demonstrating the validity of the DIS has been to

study the DIS predictive power in terms of health outcomes at follow-up. The lay interview DIS compared well to physicians' diagnoses for 370 ECA subjects at one-year follow-up for diagnostic consistency, actual health outcomes, and information about family psychiatric history in first-degree relatives (Helzer et al., 1987). The DIS validity studies have led to the improvement and revision of the DIS three times since 1981, especially for diagnoses such as Panic Disorder and Somatization Disorder.

The DIS has been translated into Spanish and has been used with patients and community samples in Puerto Rico (Canino et al., 1987). Overall, a comparison of clinician and nonclinician diagnoses with the Spanish version of the DIS shows much the same findings as with the original English version. There is good agreement in diagnoses when lay interviewers and clinicians collect data with the DIS; the poorest agreement occurs when the lay interviewer diagnosis is compared to the clinician's diagnosis obtained without the use of the DIS. For example, agreement for lay interviewers and clinicians when both used the DIS was Kappa = .55 for Major Depression, while agreement for lay interviewers' DIS diagnosis compared to clinicians' diagnosis without the use of the DIS was Kappa =. 18 for Major Depression. The specificity of the Spanish DIS for identifying disorders is good but the sensitivity (the ability to detect the presence of a problem) is more variable. This is also true for the English version of the DIS.

Scoring

The DIS items are scored in a precoded closed-ended format. Computer programs derive and designate the diagnoses according to the three diagnostic systems and indicate how recently the disorder has been active. A computerized program for a personal computer, the Apple DIS, has been developed (Comings, 1984).

Availability

The DIS interviews, manuals, and information about computer scoring are available from Lee N. Robins, PhD, Washington University School of Medicine, 4940 Audubon Avenue, St. Louis, MO 63110.

Comparison of the SADS and the DIS

A systematic investigation of the SADS and DIS was conducted with 42 patients hospitalized for the treatment of alcohol problems (Hesselbrock, Stabenau, Hesselbrock, Mirkin, & Meyer, 1982). The two interviews were conducted within three to four days of each other by different interviewers. The diagnoses were assigned with the RDC criteria. Interrater reliability was excellent, with Kappas of .83 for the SADS and .94 for the DIS. Diagnoses derived from these two interviews showed good concordance. For example, Kappas of .74 were obtained for a current diagnosis of Major Depression without subtyping and Kappas of .72 for past episodes of Major Depression. Poorer concordance between the SADS and the DIS was demonstrated for Antisocial Personality disorder and

for Drug Use.

The DIS took longer to administer (about 75-90 minutes) than the SADS (about 60-70 minutes). Overall, the SADS requires a greater investment in training time because the interviewer will be making diagnostic decisions, but the advantage of this is greater specificity in diagnoses. One of the advantages of the DIS is that it gathers more complete information in each category because there are no screening questions, diagnostic hierarchy, or interviewer judgment skip-outs. Both instruments are useful for deriving Axis I diagnoses. The DIS provides for separate coding of a medical condition or physical injury, while the SADS provides for the interviewers to rule out these factors as part of their differential diagnoses. The DIS more systematically documents overlapping medical conditions, therefore enabling an Axis III diagnosis. The SADS permits the clinician to rule out any coexisting physical condition but depends on the clinician to make the final judgment. The DIS has a component for Organic Mental Disorders while the SADS requires the clinician to judge the presence of these problems prior to administering the SADS interview. In addition, nonclinician-administered structured interviews are being used more frequently in clinical and treatment settings, expanding the application of the DIS from its original use in epidemiological surveys (Klerman, 1985).

The Structured Clinical Interview for DSM-III-R (SCID)/DSM-III-R (1987)

Modifications in the diagnostic systems over the past decade and the increased use of the DSM-III system have made the utility of the SADS interview more limited to research settings. A structured interview which was designed for the clinically trained interviewer but which derived DSM-III and DSM-III-R (American Psychiatric Association, 1980, 1987) diagnoses was needed. The Structured Clinical Interview for DSM-III-R (SCID) was developed for this purpose by Spitzer, Williams, Gibbon, and First (1988a, 1988b). The SCID is in the process of being refined and several field trials have been initiated to assess its reliability and validity. The SCID is a semistructured interview comprised of diagnostic modules for each major Axis I diagnostic category. These diagnostic modules provide the clinician or researcher with the flexibility to customize the interview and therefore to add or delete diagnostic modules that may not be relevant. The SCID assesses problems occurring within two time periods: the past month (current) and lifetime (illness occurring at any time, "ever"). The SCID is comprised of open-ended questions as well as specific probes. The interview follows the rhythm of the clinician's differential diagnostic interview. Interviewees' responses are coded in one of four ways: ? = inadequate information; 1 = absent or false; 2 = subthreshold (threshold for criterion is almost but not completely met); and 3 = threshold (criterion is met). Information about the onset, course of illness, partial or full remission, impairment or Global Assessment Functioning (GAF), and differentiation of symptoms from organic causes is documented in the SCID.

There are three versions of the SCID: (a) the Patient Version (SCID-P), (b) the Outpatient Version (SCID-OP) and (c) the Nonpatient Version (SCID-NP). The Patient Version of the SCID was designed for use with psychiatric inpatients. This version has a diagnostic module tailored for making differential diagnoses of psychotic disorders because psychotic states are more likely to be found in inpatient populations. There are nine modules in the SCID-P: mood syndromes, psychotic and associated symptoms, psychotic disorders (differential), mood disorders, psychoactive substance use disorders, anxiety disorders, somatoform disorders, eating disorders, and adjustment disorders. The SCID-P also has an overview section, which focuses on the presenting problem, and a score sheet for current and lifetime diagnoses.

In contrast to the Patient Version, the Outpatient Version (SCID-OP) is tailored for the screening of psychotic symptoms since outpatients are less likely to present in active psychotic states. There are eight modules in the SCID-OP.

The Nonpatient Version (SCID-NP) was designed for use with inpiduals not identified as psychiatric patients. Therefore, the SCID-NP is appropriate for use in community surveys, family studies, medical clinics, or other research settings. The SCID-NP, like the SCID-OP, includes only the psychotic screening module. However, the three versions of the SCID are easily converted from one to another by adding or removing the appropriate score sheet, overview, and psychotic modules.

Which Affective Disorders Are Diagnosed by the SCID?

The DSM-III-R diagnoses are Bipolar Disorder (Mania and Hypomania), Cyclothymia, Major Depression, Dysthymia, and Mood Disorders Not Otherwise Specified.

Who Administers the SCID?

A clinician who is familiar with psychopathology and experienced in differential diagnosis should administer the interview because clinician judgments for thresholds of criteria are required.

How Much Time Is Required to Administer the SCID?

A SCID may be administered in about one hour, but the time to administer will vary with the clinical condition of the respondent.

Reliability

Recently, the reliability of the SCID interview and its ability to differentiate between Major Depression and Generalized Anxiety Disorders was tested in 75 outpatients (Riskind, Beck, Berchick, Brown, & Steer, 1987). Interrater agreement for the clinician's initial diagnosis derived with the SCID interview and a second clinician's rating of the videotaped interview yielded high overall diagnostic agreement with 83 percent agreement and a Kappa coefficient of .74. Agreement

for the SCID diagnosis of Major Depression was Kappa = .72, showing good agreement between raters for this diagnostic category. The SCID has been translated into Chinese and was used to diagnose 42 psychiatric inpatients hospitalized in China (Wilson & Young, 1988). An American psychiatrist conducted a SCID interview with patients, using a translator, and assigned DSM-III diagnoses. Within seven days a Chinese psychiatrist reinterviewed these patients without the SCID and assigned diagnoses using the Chinese system. Seventy-nine percent of the patients received the same diagnosis. The nine cases of disagreement were largely in the diagnostic category of Schizophrenia and Schizoaffective Disorders.

Validity

A comparison of the SCID and the DIS and their ability to derive similar diagnoses was tested on 41 inpatients hospitalized for the treatment of substance use, who were interviewed seven to 21 days after admission (Rounsaville, Kosten, Williams, & Spitzer, 1987). Diagnostic agreement between DSM-III (DIS interviews) and DSM-III-R (SCID interviews) was satisfactory for Alcohol, Barbiturates, and Cannabis use with Kappas of .78, .74, .77, respectively. The DSM-III-R system of diagnosis was shown to increase the likelihood of diagnosing inpiduals as meeting criteria for alcohol use because one of the DSM-III criteria, alcohol behavior leading to social consequences, has been removed. The SCID may also be sensitive for differentiating syndromes in which there is symptom

similarity, such as Anxiety Disorders (Riskind et al., 1987). More information about the reliability and validity of the SCID will be forthcoming as the field trials are completed.

Scoring

The SCID interview contains a detailed summary score sheet which the clinician completes with use of the DSM-III-R manual for the diagnostic criteria. The SCID instruments are precoded for data entry. A computer scoring system is not currently available.

Availability

The SCID has been translated into several foreign languages and is being used in Japan, Puerto Rico, and China.

The SCID interviews come with a detailed instruction manual (Spitzer et al., 1988a). Instructional videotapes as well as SCID workshops are available for training in the use of the SCID.

Information about the SCID interviews and training may be obtained by writing to Robert Spitzer, MD, Janet B. Williams, PhD, or Miriam Gibbon, MSW, at Biometrics Research Department, New York State Psychiatric Institute, 722 West 168th Street, New York, NY 10032.

NEW INSTRUMENTS

The overwhelming popularity of structured diagnostic instruments for use both in research and in clinical settings has lead to continued work in the development of new instruments or the updating of more well established instruments. Information about these newer instruments may assist the interested reader in following further developments in the literature.

The Composite International Diagnostic Interview (CIDI)/International Statistical Classification of Diseases, Injuries, and Causes of Death, Ninth Revised Edition (ICD-9); DSM-III (1980) and DSM-III-R (1987)

In 1979 the World Health Organization (WHO) and the United States Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) began a collaboration to work toward establishing more uniform diagnostic definitions and criteria for the investigation of mental, alcohol, and drug disorders worldwide. A task force on diagnostic instruments had been mandated to create two diagnostic interviews, one to be used with clinical populations and the other with the general population. The Composite International Diagnostic Interview (CIDI; Robins et al., 1988) was created for the purpose of diagnostic assessment in the general population. To date, most European investigators have relied on the clinician-administered Present State Examination (PSE; Wing, Cooper, & Sartorius, 1974) and the International Statistical Classification of Diseases . . . (ICD-9; WHO, 1977). In the 1980s, use of the DIS with large segments of the United States

population and with international populations convinced investigators of the feasibility of using this instrument for deriving diagnoses with the three diagnostic systems. Therefore, the development of the CIDI was based on combining 63 PSE items with the components and overall format of the DIS. The CIDI is similar in structure and format to the DIS. It is a structured interview that may be administered by a nonclinician. The questions are fully spelled out and the responses are codes in a closed-ended format. Clinical judgment is not a part of the decision-making process in the coding of responses. The CIDI is scored and the 40 DSM-III diagnostic categories (American Psychiatric Association, 1980) are derived with the use of a computer. Initial field trials of the CIDI began in 1988, and the CIDI is being tested worldwide at 19 sites (see Robins et al., 1988, pp. 1074-1075 for details). The CIDI will not only be updated to derive ICD-10 and DSM-III-R diagnoses but also will provide comparability to previous work in the field by retaining both DSM-III and PSE diagnoses.

In contrast to the CIDI, which will be used for the general population, the proposed international diagnostic instrument for use with clinical populations is the Schedule for Clinical Assessment in Neuropsychiatry (SCAN) (Robins et al., 1988). Information about this instrument will be forthcoming.

The creation of these diagnostic instruments and the development of more uniform criteria for diagnoses move investigators closer to the realization of the goals of more reliable cross-cultural comparisons, more uniform methods of

communication about diagnoses, and more precise information about mental health worldwide.

SUMMARY

This chapter discussed the most reliable and frequently used interviewing methods available for the diagnosis of Affective Disorders. Interviews described are (a) the Schedule for Affective Disorders and Schizophrenia, (b) the Diagnostic Interview Schedule, (c) the Structured Clinical Interview for DSM-III-R, (d) the Composite International Diagnostic Interview, and (e) the Schedule for Clinical Assessment in Neuropsychiatry. Each interview method has been designed for use with a companion diagnostic system, (a) the Feighner Criteria, (b) the Research Diagnostic Criteria, (c) the Diagnostic and Statistical Manual of Mental Disorders, and (d) the International Statistical Classification of Diseases, Injuries, and Causes of Death. Descriptions were given about personnel qualified to administer the interviews, the time required, the scoring procedures and sources for obtaining the interview schedules. Finally, the diagnostic reliabilities, sensitivities, specificities, and documentation of the validity of diagnoses obtained with these interviewing methods were presented. This chapter will assist the clinician or researcher in choosing appropriate interviewing methods for the diagnosis and assessment of Affective Disorders.

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